

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No.</b>	03/CVDS/0032
<b>Service</b>	<b>Cardiology: secondary care based heart failure services</b>
<b>Commissioner Lead</b>	Clinical Commissioning Programme for Cardiovascular Disease and Stroke
<b>Provider Lead</b>	
<b>Period</b>	
<b>Date of Review</b>	

#### 1. Population Needs

##### 1.1 National/local context and evidence base

###### **National Context**

Heart failure is a complex syndrome that can result from any structural or functional cardiac disorder that impairs the ability to effectively pump enough blood to meet the body's needs. It is often characterised by symptoms of shortness of breath, fatigue and signs of fluid retention. There may also be additional symptoms, such as chest pain or a persistent cough; although sometimes the heart may already be failing before any symptoms develop.

Heart Failure affects one in a hundred people in the UK; around 620,000 people, increasing to around 7 per cent over the age of 75.

The National Heart Failure Audit has highlighted that within a year of admission for heart failure, 32% of patients have died, however, mortality is significantly lower for those who have access to specialist care i.e. those seen by a cardiologist or specialist heart failure service. Inpatient mortality is also twice as likely for a heart failure patient if they are on a non-cardiac ward.

Although there has been a decline in mortality from coronary heart disease, there has been a subsequent increase in patients living with heart failure. As this is a condition which mainly affects older people, it will become more prevalent with our ageing population<sup>1</sup>. In the UK, the most common cause of heart failure is coronary heart disease, with many patients having a history of myocardial infarction (MI). However, a history of hypertension or atrial fibrillation is also common<sup>2</sup>. In Dorset the prevalence of AF is higher than the national average.

Heart failure currently accounts for a total of 1 million inpatient bed days, 2% of all NHS inpatient bed days and 5% of all emergency medical admissions to hospital<sup>3</sup>. However, with the predicted increase in the number of people living with heart failure hospital admissions are also projected to rise. The effects of heart failure on a patient's quality of life can be significant, mainly due to the physical limitations of the condition which then lead to social limitations and the possibility of anxiety and depression.

###### **Local Context**

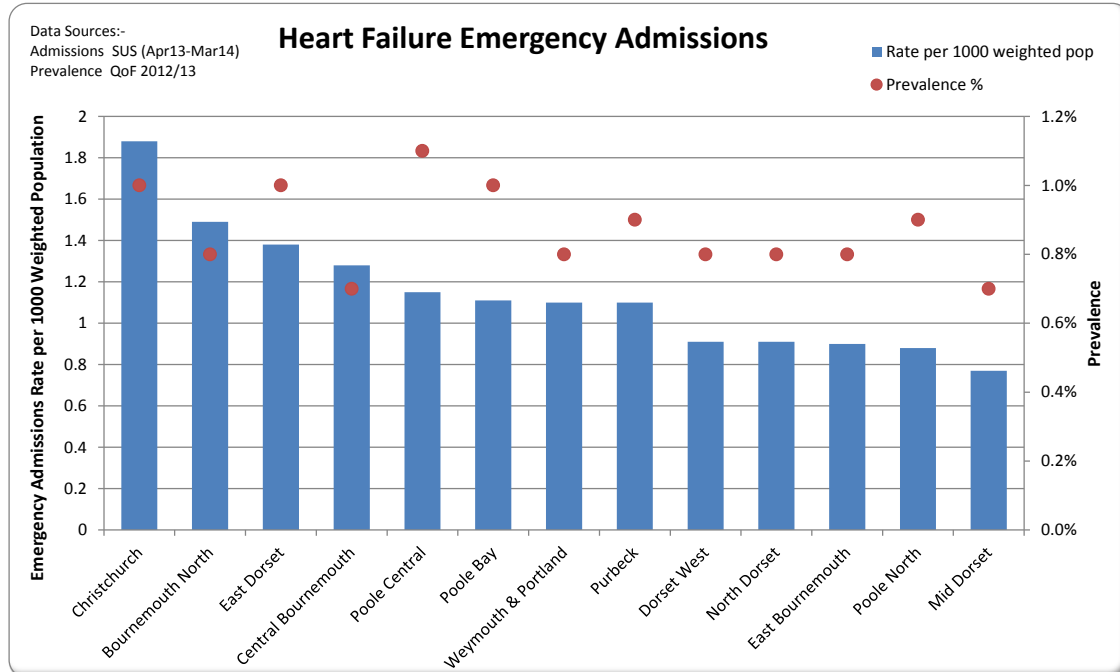
<sup>1</sup> Bridging the quality gap: Heart failure (2010)

<sup>2</sup> European Society of Cardiology :Guidelines for the diagnosis and treatment of acute and chronic heart failure (2012)

<sup>3</sup> NICE, Management of chronic heart failure in adults in primary and secondary care (2010)

In 2013/14 there were 924 admissions classified as heart failure with the main providers to Dorset practices. This was in line with the previous years activity.

### Emergency Admissions For Heart Failure Per 1000 Weighted Population and Prevalence



Data Period April 12- March 13 for activity with a primary diagnosis of heart failure

Prevalence data by practice from 2011-12

### Heart failure emergency admissions

As already acknowledged, heart failure is a condition which generally affects the elderly population and incidence increases greatly with age. The prevalence and admission pattern has changed over the last year. Prevalence recording in primary care is improving slowly across the board but is still about half expected levels, and there was a small improvement in non-elective emergency admissions to Poole Hospital.

### Evidence base

This service specification has been developed in line with:

- The National Institute for Health and Clinical Excellence (NICE) Guideline for Management of Chronic Heart Failure (2010) and NICE Chronic Heart Failure Quality Standards (2011);
- The National Service Framework for Coronary Heart Disease (2000);
- The service specification recommended by Wessex CVD Network.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	Yes
Domain 2	Enhancing quality of life for people with long-term conditions	Yes
Domain 3	Helping people to recover from episodes of ill-health or following injury	Yes
Domain 4	Ensuring people have a positive experience of care	Yes
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	Yes

## 2.2 Local defined outcomes

- Provide a multidisciplinary service for patients with heart failure that is fully adherent to newly published NICE guidance (August 2010) and incorporates the NICE quality standards (June 2011);
- People with heart failure and their families are involved in the planning and delivery of their care;
- Increase the quality of life and life expectancy of all patients with heart failure in line with national expectations;
- Reduce health inequalities in the provision of heart failure care between those in the most and least deprived areas;
- Ensure seamless provision of care of patients with heart failure by promoting greater integration between primary and secondary care services.

## 3. Scope

### 3.1 Aims and objectives of service

#### Aims

The aim of the service is to provide a comprehensive, patient-centred, secondary care acute heart failure service, delivering care to people with suspected or proven heart failure\*; where this is directly related to their presenting condition or as a co-morbidity.

\*Heart Failure with Normal Ejection Fraction (HFNEF) shares the same treatment goals as Left Ventricular Systolic Dysfunction (LVSD) apart from those relating to beta blocker or ACE prescribing where there is no definitive evidence.

The service will provide confirmation of diagnosis, assessment, education, initiation of medication and monitoring of adult patients with heart failure in both an outpatient and inpatient setting, across all specialities and departments. In addition, the service will provide advice on the management of patients in primary care/the community setting when requested. This advice may be provided through various mechanisms, e.g. email, formal/informal meetings and phone conversations but must allow for support and advice in a timely fashion and as required.

#### One Stop Rapid Access Heart Failure Clinics (Early diagnosis and prevention of admission)

- People with suspected heart failure and previous MI or suspected heart failure and high serum natriuretic peptide levels will be seen by a specialist and have an echocardiogram within 2 weeks<sup>4</sup>. This will ideally be in a one stop clinic
- People with suspected heart failure and intermediate serum natriuretic peptide (SNP) levels will be seen by a specialist and have an echocardiogram within 6 weeks of referral<sup>4</sup>. This will ideally be in a one stop clinic or direct access echo prior to consultation.
- People diagnosed with heart failure will be prescribed medications as per NICE Guidance.

<sup>4</sup> NICE Heart Failure Quality Standards (2011)

- People diagnosed with chronic heart failure will be provided with personalised information, education, support and opportunities for discussion throughout their care to help them understand their condition and be involved in its management, if they wish<sup>7</sup>. Information on appropriate voluntary organisations will also be provided to patients and the people that care for them.
- Personalised management plans will be provided to heart failure patients, their carer(s), their GP and community services<sup>4</sup>;
- Referrals will be made to the heart failure specialist nurses in community roles in line with their service specifications.

#### Inpatient services

- All patients admitted with suspected heart failure will have their diagnosis confirmed by echo or other appropriate imaging modality (MRI, Myoview, MUGA scan).
- People with a confirmed diagnosis will be referred to the Trust heart failure specialist team for advice on their management during their inpatient stay. This advice will also form part of the management plan on discharge<sup>7</sup>.
- Protocols should be in place to identify those patients best treated in a cardiac care unit.
- People diagnosed with heart failure will be prescribed medications as per NICE Guidance.
- Patients will be assessed for interventional procedures such as cardiac resynchronisation, internal defibrillators (CRT/CRTD), revascularisation, restorative surgery and transplantation as per national guidance. Support and counselling will be provided for patients undergoing these interventions.
- People diagnosed with chronic heart failure will be provided with personalised information, education, support and opportunities for discussion throughout their care to help them understand their condition and be involved in its management, if they wish<sup>4</sup>. Information on appropriate voluntary organisations will also be provided to patients and the people that care for them.
- People admitted to hospital for heart failure are discharged only when it is safe to do so with appropriate clinical follow up, either from the hospital heart failure team or by a member of the heart failure specialist nurse team in community roles, within 2 weeks of discharge (this is covered by the community HF specialist nursing service specification).
- The service will collaborate closely with the heart failure specialist nurses in community roles.
- Trusts should hold regular mortality clinical governance meetings to review inpatient deaths from heart failure.

#### Additional outpatient services

- Limited out-patient follow up will be provided; where the patient is deemed as needing specialist consultant led follow-up that cannot be provided in primary care/community services.
- Appointments will be available for patients with an established diagnosis of heart failure with new complications or rapid deterioration and provide early investigation of precipitating cause and management.
- Protocols will be in place for the identification of patients suitable for interventional procedures such as cardiac resynchronisation, internal defibrillators (CRT/CRTD), revascularisation, restorative surgery and transplantation as per national guidance. Support and counselling will be provided to patients undergoing these interventions. Referral rates for CRT/CRTD should in accordance with national guidance.
- The service will consider the role of Telehealth in a patient pathway as a step to support self-care as part of their transit to less medical support and follow up.

### Liaison with other stakeholders (Multidisciplinary working)

- Regular MDT meetings will take place to allow discussions between heart failure specialists and community nurses.
- People with stable chronic heart failure and no precluding condition or device will be offered access to a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support.
- Referral pathways will allow patients and carers access to psychological support to assist them in living with their long term condition (this will be achieved through links with steps to well being).
- Implanting centres will have procedures in place for deactivation of internal defibrillators at the end of life. Deactivation will remain the responsibility of the implanting centre and include a home visit service where necessary.
- The palliative needs of patients and carers should be identified, assessed and managed at the earliest opportunity. This may be triggered by the use of agreed disease markers. Patients and their carers should have access to professionals with palliative care skills within the heart failure team and there should be established pathways to involve palliative care specialists. Training in communication skills should be undertaken by all heart failure nurse specialists designated to undertake these challenging discussions.
- Referral pathways should also be in place for bereavement support for the carer(s) and family of heart failure patients. Pathways should also include links to voluntary organisations.

### **Objectives**

- The service will meet the requirements of the NICE Heart Failure Guidance (2010) and NICE Quality Standards (2011);
- The service will act as a resource to primary and community services;
- High risk patients with heart failure will receive prompt outpatient service review;
- Each patient will receive specialist input into their care;
- There will be an increase in uptake of proven pharmacological agents, notably ACE inhibitors and Beta blockers;
- There will be increased links with palliative care in relation to secondary and tertiary care provision;
- All trusts should submit complete data on heart failure admissions to the National Heart Failure Audit.

### **3.2 Service description/care pathway**

There is explicit expectation that the provider will provide a specialist heart failure consultant, who is the named lead for the service. There will be an inpatient nurse expertise. Allied health professionals with specialist skills and administrative staff usually found in an acute hospital setting will also make up part of the team. All members of the team will have or be working towards appropriate competencies.

The service will be supported by investigation facilities and will cover:

- Rapid access, one stop assessment clinics
- All in-patient services (non-elective and elective), particularly cardiology, general medicine and care of older people.
- Consultant Cardiologist outpatient clinics for heart failure

The service will be expected to work in partnership with other primary, secondary and tertiary care colleagues and agencies to ensure a smooth patient journey across the whole patient pathway; from diagnosis to end of life care. Self-care will be encouraged and patients and carers will be actively involved in the development of care plans and the management of their condition. Systems will also be in place to provide those cared for with a single point of contact for the team. Telehealth will be

considered within patient pathways.

The service will provide evidence based care and will be compliant with the most up to date guidelines for management of adults with heart failure in a secondary care setting.

Limited monitoring will be provided in the outpatient setting for cases that are found to be difficult to manage by primary care/community services. However, once these patients have been stabilised, they will be referred back to primary care/community services with a clear management plan in place.

For patients with an established diagnosis of heart failure, who then experience complications or rapid deterioration, the provider will offer early investigation of precipitating cause and management to prevent admission or reduce length of admission if necessary.

National Heart Failure Audit: in line with the Healthcare Quality Improvement Partnership (HQIP) requirements, from April 2013 onwards, hospitals will be required to enter all of their patients with a primary diagnosis of heart failure into the audit. This requirement will be instrumental in improving the accuracy and usefulness of the data and it means that the hospital level analysis will be truly reflective of the clinical practice in hospitals.

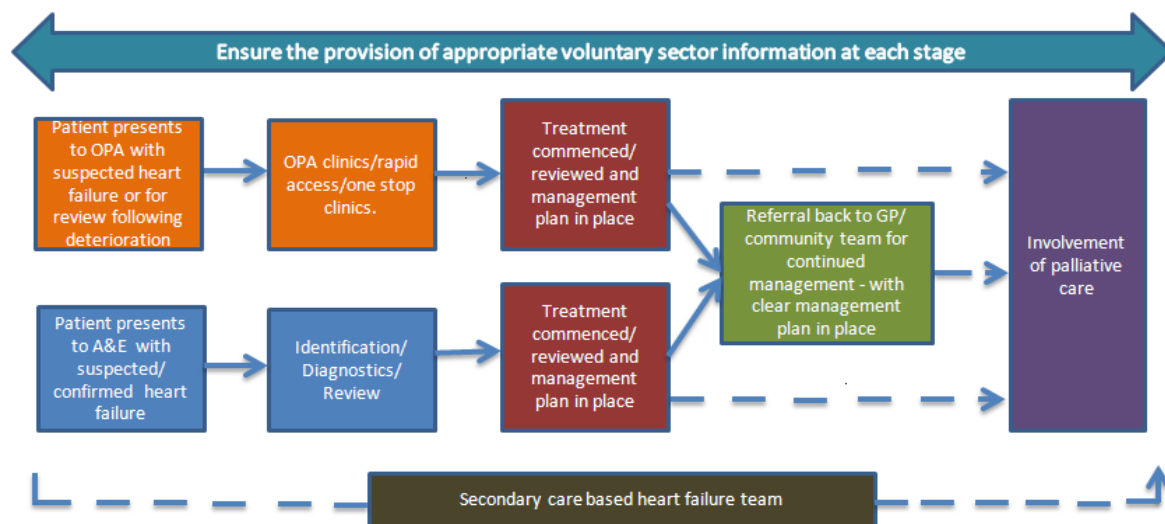
Case ascertainment is measured against HES recorded numbers of patients with a primary diagnosis of heart failure. Where HES data is inaccurate records should be re-coded to improve HES data accuracy.



Service components of a successful heart failure service<sup>1</sup>:



early diagnosis in outpatients	heart failure admissions/ inpatients	treatment	team working	palliative care
<ul style="list-style-type: none"> <li>-Rapid access HF clinics</li> <li>- Echo on the day of clinical assessment</li> <li>- Management plan produced on the day</li> </ul>	<ul style="list-style-type: none"> <li>-Early inpatient echo, +/- BNP testing</li> <li>- referral protocols for specialist HF services</li> <li>- Inpatient assessment by heart failure specialist</li> </ul>	<ul style="list-style-type: none"> <li>- Agreed care plan</li> <li>- Patient education to facilitate self – management</li> <li>- Access to HF rehab</li> <li>- Protocols to identify patients who are suitable for advanced therapies</li> <li>- Close liaison with community/primary care over discharge planning</li> </ul>	<ul style="list-style-type: none"> <li>- HF consultant lead</li> <li>- HF nurses in post in acute and community roles</li> <li>- Case management discussions across primary and secondary care</li> <li>- Discharged with management plan in place</li> <li>- Links with adult social care and voluntary organisations</li> </ul>	<ul style="list-style-type: none"> <li>- Palliative care involvement</li> <li>- Advanced directives to guide admission requirements at the end of life.</li> </ul>



### 3.3 Population covered

Please refer to section 1.1 (local context).

### 3.4 Any acceptance and exclusion criteria and thresholds

#### Referrals will be accepted for:

Acute inpatients: via emergency department or admitting medical or surgical teams

OPA: within 2 weeks (RAHFC) with signs and symptoms of heart failure and previous MI or high levels of serum natriuretic peptide levels.

Within 6 weeks if heart failure is considered a potential diagnosis with intermediate serum natriuretic peptide levels or where there is an existing diagnosis of heart failure with deterioration or alteration in condition.

A past diagnosis of heart failure not confirmed by Echocardiogram

When there is an existing diagnosis of heart failure, where advanced therapies may be appropriate

### **Exclusion criteria**

Patients will not be accepted into the service if they;

- Are under 18 years of age;
- Are pregnant (pregnant women will be referred to specialist services).

### **3.5 Interdependence with other services/providers**

#### **2.5 Interdependencies with other services**

- Intradepartmental: radiography, biochemistry, pathology, diagnostics, pharmacy and others as necessary;
- Consultant to consultant referrals kept within planned contracted activity and to follow agreed pathways of investigation;
- General Practice;
- Community Service Providers particularly the HF specialist nurses;
- Social Services - the service will make onward referrals to local authority social services when necessary after an initial assessment of the patient and at any point that this becomes appropriate;
- Interpreting Services - the service will need to provide an interpreter when this is necessary to ensure that the Service is inclusive by telephone or face to face interpretation as appropriate;
- Cardiac rehabilitation;
- Transport services
- Community Pharmacy
- Palliative Care

## **4. Applicable Service Standards**

### **4.1 Applicable national standards (e.g. NICE)**

#### **NICE Guidance**

#### **CG108 Chronic heart failure: full guideline**

#### **NICE quality standard: CG108 Chronic heart failure**

The Trust is expected to adhere and contribute to the National Heart Failure Audit.

### **4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**

### **4.3 Applicable local standards**

## **5. Applicable quality requirements and CQUIN goals**

### **5.1 Applicable quality requirements (See Schedule 4 Parts A-D)**

### **5.2 Applicable CQUIN goals (See Schedule 4 Part E)**

## **6. Location of Provider Premises**



The Provider's Premises are located at:

**7. Individual Service User Placement**

## QUALITY REQUIREMENTS

### A. Local Quality Requirements (B8)

	Quality requirement	Threshold	Method of measurement	Consequence of breach
1.	<b>OPA Clinics:</b> People with suspected heart failure receive specialist assessment including echocardiography within recommended NICE (2010) time frames.	95% (+/- 5%) of people with suspected heart failure and <b>previous MI or high</b> serum natriuretic peptide levels are seen <b>within 2 weeks</b> of referral or <b>within 6 weeks</b> of referral <b>with intermediate levels.</b>	<i>Rapid access one-stop clinics in place.</i>  <u>Numerator:</u> the number of people in the denominator <b>seen</b> by a specialist and having an echocardiography within 2 weeks/6 weeks of referral.  <u>Denominator:</u> the number of people <b>referred</b> for specialist assessment including echocardiography either because of <ul style="list-style-type: none"> <li>• suspected heart failure and previous MI or suspected heart failure and high serum natriuretic peptide levels (2 weeks) <b>or</b></li> <li>• suspected heart failure and intermediate serum natriuretic peptide levels (6 weeks)</li> </ul>	Service review
2.	Participation in the <b>National Heart Failure Audit</b> (National requirement).	95% (+/- 5%) submission rate against HES data (from April 2013)	<i>National Heart Failure Audit annual report published every November and NICOR's local on-line audit tool.</i>  <u>Numerator:</u> the number of patient records submitted to the audit.  <u>Denominator:</u> the number of patients with a primary discharge diagnosis of heart failure (HES data).	Service review
3.	People with heart failure are reviewed by a <b>multidisciplinary heart failure team</b> , led by a specialist and consisting of professionals with appropriate competencies (NICE Quality Standard 2011).	At least 85% of patients recorded on the National Heart Failure Audit are reviewed by the specialist HF team during admission.	<i>Specialist Heart Failure Physician in place who is the named clinical lead for the service.</i>  <i>Heart Failure Nurse Specialist(s) in place</i>  <u>Numerator:</u> the number of people reviewed by a consultant with an interest in heart failure/ heart failure specialist nurse during admission, as recorded by the National Heart Failure Audit.  <u>Denominator:</u> the number of people captured within the National Heart Failure Audit.	Service review
4.	<b>Readmission rates:</b> number of patients readmitted within 29 days of discharge with a primary discharge diagnosis of heart	Trusts will strive for the lowest readmission rates achievable in the context of providing good quality heart failure care but	<u>Numerator:</u> the number of patients with a primary discharge diagnosis of heart failure readmitted within 29 days of their discharge date, as recorded by the National Heart Failure Audit.  <u>Denominator:</u> The number of patients discharged from hospital with a primary	Service review

	failure.	need to undertake a formal review should they be reported in the <b>top quintile of published readmission rate data</b> (National Heart Failure Audit report)	diagnosis of heart failure as recorded by the National Heart Failure Audit.	
5.	<b>In-hospital mortality:</b> the number of patients dying during admission with a primary diagnosis of heart failure.	Trusts will strive for the lowest mortality rates achievable in the context of providing good quality heart failure care but need to undertake a formal review should they be reported in the <b>top quintile of published mortality data</b> (National Heart Failure Audit report)	<p><u>Numerator:</u> the number of patients with a primary diagnosis of heart failure who die during admission, as recorded on the National Heart Failure Audit.</p> <p><u>Denominator:</u> The number of patients discharged from hospital with a primary diagnosis of heart failure, as recorded on the National Heart Failure Audit.</p>	Service review